300.81 Somatization Disorder

Diagnostic Features

The essential feature of Somatization Disorder is a pattern of recurring, multiple, clinically significant somatic complaints. A somatic complaint is considered to be clinically significant if it results in medical treatment (e.g., the taking of medication) or causes significant impairment in social, occupational, or other important areas of functioning. The somatic complaints must begin before age 30 years and occur over a period of several years (Criterion A). The multiple somatic complaints cannot be fully explained by any known general medical condition or the direct effects of a substance. If they occur in the presence of a general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory tests (Criterion C). There must be a history of pain related to at least four different sites (e.g., head, abdomen, back, joints, extremities, chest, rectum) or functions (e.g., menstruation, sexual intercourse, urination) (Criterion B1). There also must be a history of at least two gastrointestinal symptoms other than pain (Criterion B2). Most individuals with the disorder describe the presence of nausea and abdominal bloating. Vomiting, diarrhea, and food intolerance are less common. Gastrointestinal complaints often lead to frequent X-ray examinations and can result in abdominal surgery that in retrospect was unnecessary. There must be a history of at least one sexual or reproductive symptom other than pain (Criterion B3). In women, this may consist of irregular menses, menorrhagia, or vomiting throughout pregnancy. In men, there may be symptoms such as erectile or ejaculatory dysfunction. Both women and men may be subject to sexual indifference. Finally, there must also be a history of at least one symptom, other than pain, that suggests a neurological condition (conversion symptoms such as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, or seizures; dissociative symptoms such as amnesia; or loss of consciousness other than fainting) (Criterion B4). The symptoms in each of the groups have been listed in the approximate order of their reported frequency. Finally, the unexplained symptoms in Somatization Disorder are not intentionally feigned or produced (as in Factitious Disorder or Malingering) (Criterion D).

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with Somatization Disorder usually describe their complaints in colorful, exaggerated terms, but specific factual information is often lacking. They are often inconsistent historians, so that a checklist approach to diagnostic interviewing may be less effective than a thorough review of medical treatments and hospitalizations to document a pattern of frequent somatic complaints. They often seek treatment from several physicians concurrently, which may lead to complicated and sometimes hazardous combinations of treatments. Prominent anxiety symptoms and depressed mood are very common and may be the reason for being seen in mental health settings. There may be impulsive and antisocial behavior, suicide threats and attempts, and marital discord. The lives of these individuals, particularly those with associated Personality Disorders, are often as chaotic and complicated as their medical histories. Frequent use of medications may lead to side effects and Substance-Related Disorders. These individuals commonly undergo numerous medical examinations, diagnostic procedures, surgeries, and hospitalizations, which expose the person to an increased risk of morbidity associated with these procedures. Major Depressive Disorder, Panic Disorder, and Substance-Related Disorders are frequently associated with Somatization Disorder. Histrionic, Borderline, and Antisocial Personality Disorders are the most frequently associated Personality Disorders.

Associated laboratory findings. Laboratory test results are remarkable for the absence of findings to support the subjective complaints.

Associated physical examination findings and general medical conditions. Physical examination is remarkable for the absence of objective findings to fully explain the many subjective complaints of individuals with Somatization Disorder. These individuals may be diagnosed with so-called functional disorders (e.g., irritable bowel syndrome). However, because these syndromes are as yet without established objective signs or specific laboratory findings, their symptoms may count toward a diagnosis of Somatization Disorder.

Specific Culture and Gender Features

The type and frequency of somatic symptoms may differ across cultures. For example, burning hands and feet or the nondelusional experience of worms in the head or ants crawling under the skin represent pseudoneurological symptoms that are more common in Africa and South Asia than in North America. Symptoms related to male reproductive function may be more prevalent in cultures in which there is widespread concern about semen loss (e.g., *dhat* syndrome in India). Accordingly, the symptom reviews should be adjusted to the culture. The symptoms listed in this manual are examples that have been found most diagnostic in the United States. It should be noted that the order of frequency was derived from studies done in the United States.

Somatization Disorder occurs only rarely in men in the United States, but the higher reported frequency in Greek and Puerto Rican men suggests that cultural factors may influence the sex ratio.

Prevalence

Studies have reported widely variable lifetime prevalence rates of Somatization Disorder, ranging from 0.2% to 2% among women and less than 0.2% in men. Differences in rates may depend on whether the interviewer is a physician, on the method of assessment, and on the demographic variables in the samples studied. When nonphysician interviewers are used, Somatization Disorder is much less frequently diagnosed.

Course

Somatization Disorder is a chronic but fluctuating disorder that rarely remits completely. A year seldom passes without the individual seeking some medical attention prompted by unexplained somatic complaints. Diagnostic criteria are typically met before age 25 years, but initial symptoms are often present by adolescence. Menstrual difficulties may be one of the earliest symptoms in women. Sexual symptoms are often associated with marital discord.

Familial Pattern

Somatization Disorder is observed in 10%–20% of female first degree biological relatives of women with Somatization Disorder. The male relatives of women with this disorder show an increased risk of Antisocial Personality Disorder and Substance-Related Disorders. Adoption studies indicate that both genetic and environmental factors contribute to the risk for Antisocial Personality Disorder, Substance-Related Disorders, and Somatization Disorder. Having a biological or adoptive parent with any of these disorders increases the risk of developing either Antisocial Personality Disorder, a Substance-Related Disorder, or Somatization Disorder.

Differential Diagnosis

The symptom picture encountered in Somatization Disorder is frequently nonspecific and can overlap with a multitude of **general medical conditions.** Three features that suggest a diagnosis of Somatization Disorder rather than a general medical condition include 1) involvement of multiple organ systems, 2) early onset and chronic course without development of physical signs or structural abnormalities, and 3) absence of laboratory abnormalities that are characteristic of the suggested general medical condition. It is still necessary to rule out general medical conditions that are characterized by vague, multiple, and confusing somatic symptoms (e.g., hyperparathyroidism, acute intermittent porphyria, multiple sclerosis, systemic lupus erythematosus). Moreover, Somatization Disorder does not protect individuals from having other independent general medical conditions. Objective findings should be evaluated without undue reliance on subjective complaints. The onset of multiple physical symptoms late in life is almost always due to a general medical condition.

Schizophrenia with multiple somatic delusions needs to be differentiated from the nondelusional somatic complaints of individuals with Somatization Disorder. In rare instances, individuals with Somatization Disorder also have Schizophrenia, in which case both diagnoses should be noted. Furthermore, hallucinations can occur as pseudoneurological symptoms and must be distinguished from the typical hallucinations seen in Schizophrenia (see p. 275).

It can be very difficult to distinguish between **Anxiety Disorders** and Somatization Disorder. In **Panic Disorder,** multiple somatic symptoms are also present, but these occur primarily during Panic Attacks. However, Panic Disorder may coexist with Somatization Disorder; when the somatic symptoms occur at times other than during Panic Attacks, both diagnoses may be made. Individuals with **Generalized Anxiety Disorder** may have a multitude of physical complaints associated with their generalized anxiety, but the focus of the anxiety and worry is not limited to the physical complaints. Individuals with **Mood Disorders,** particularly **Depressive Disorders,** may present with somatic complaints, most commonly headache, gastrointestinal disturbances, or unexplained pain. Individuals with Somatization Disorder have physical complaints recurrently throughout most of their lives, regardless of their current mood state, whereas physical complaints in Depressive Disorders are limited to episodes of depressed mood. Individuals with Somatization Disorder also often present with depressive complaints. If criteria are met for both Somatization Disorder and a Mood Disorder, both may be diagnosed.

By definition, all individuals with Somatization Disorder have a history of pain symptoms, sexual symptoms, and conversion or dissociative symptoms. Therefore, if these symptoms occur exclusively during the course of Somatization Disorder, there should not be an additional diagnosis of **Pain Disorder Associated With Psychological Factors, a Sexual Dysfunction, Conversion Disorder,** or a **Dissociative Disorder. Hypochondriasis** is not be diagnosed if preoccupation with fears of having a serious illness occurs exclusively during the course of Somatization Disorder.

The criteria for Somatization Disorder in this manual are slightly more restrictive than the original criteria for **Briquet's syndrome.** Somatoform presentations that do not meet criteria for Somatization Disorder should be classified as **Undifferentiated Somatoform Disorder** if the duration of the syndrome is 6 months or longer, or **Somatoform Disorder Not Otherwise Specified** for presentations of shorter duration.

In **Factitious Disorder With Predominantly Physical Signs and Symptoms** and **Malingering,** somatic symptoms may be intentionally produced to assume the sick role or for gain, respectively. Symptoms that are intentionally produced should not count toward a diagnosis of Somatization Disorder. However, the presence of some factitious or malingered symptoms, mixed with other nonintentional symptoms, is not uncommon. In such mixed cases, both Somatization Disorder and a Factitious Disorder or Malingering should be diagnosed.

■ Diagnostic criteria for 300.81 Somatization Disorder

A. A history of many physical complaints beginning before age 30 years that occur over a period of several years and result in treatment being sought or significant impairment in social, occupational, or other important areas of functioning.

B. Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance:

(1) *four pain symptoms:* a history of pain related to at least four different sites or functions (e.g., head, abdomen, back, joints, extremities, chest, rectum, during menstruation, during sexual intercourse, or during urination)

(2) *two gastrointestinal symptoms:* a history of at least two gastrointestinal symptoms other than pain (e.g., nausea, bloating, vomiting other than during pregnancy, diarrhea, or intolerance of several different foods)

(3) *one sexual symptom:* a history of at least one sexual or reproductive symptom other than pain (e.g., sexual indifference, erectile or ejaculatory dysfunction, irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy)

(4) *one pseudoneurological symptom:* a history of at least one symptom or deficit suggesting a neurological condition not limited to pain (conversion symptoms such as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures; dissociative symptoms such as amnesia; or loss of consciousness other than fainting)

(continued)

☐ **Diagnostic criteria for 300.81 Somatization Disorder** (*continued*)

C. Either (1) or (2):

(1) after appropriate investigation, each of the symptoms in Criterion B cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication)

(2) when there is a related general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory findings

D. The symptoms are not intentionally produced or feigned (as in Factitious Disorder or Malingering).